Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHRISTINE VIDOURIA MD
3100 TIMMONS LN STE 250
HOUSTON TX 77027

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-12-1576-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Carrier refuses to pay full amount due for services rendered even after a request for reconsideration was submitted."

Amount in Dispute: $65.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office concluded the audits in questions were properly reviewed pursuant to the applicable Division Medical Fee Guidelines and the correct ANSI codes were used to explain the audit rationale to the health care provider. The Office could have allowed reimbursement for CPT Code 99456 (-MI) billed at $50.00, but instead maintained proper denial for the non-compensable body areas of the right elbow. Review of the claim file in queston shows that the injured worker reported an injury to his Right wrist/hand on 5/2/11. The claim documents further revealed that the adjuster filed a PLN-11 on 9/30/2011 disputed the right wrist tear and DeQuervains, these conditions were not evaluated for impairment. The requestor failed to submit substantiating evidence to warrant or justify the evaluation and additional reimbursement of the non-compensable body area(s) of the right elbow as the injured employee has not complained of the right elbow to the carrier or her treating physician as stated in the designated doctor's report. Therefore the Office reimbursed the evaluating physician for the upper extremity impairment rating pursuant to the rules at $300.00, utilizing the ROM calculation as stated in the requestor's report."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2011	CPT Code 99456-MI	$50.00	$0.00
	CPT Code 99080-73	$15.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. This request for medical fee dispute resolution was received by the Division on January 12, 2012.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated November 7, 2011:
   - 50 – These are non-covered services because this is not deemed a 'Medical Necessity' by the payer.
   - T13 – Medical necessity denial. You may submit a request for appeal/reconsideration no later than 11 months from the date of service.
   - 97 – Payment is included in the allowance for another service/procedure.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Is the speciality report, DWC-73, eligible for reimbursement in accordance with 28 Texas Administrative Code §134.204 and is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(b) states that a request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability. Review of the documentation submitted for CPT Code 99456-MI does not show that the medical necessity was resolved before the request for medical fee dispute resolution.
2. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate process for unresolved issues of extent of injury requiest the filing of a benefit review conference. The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. According to the Commissioner Order for the request for a designated doctor examination the purpose of the examination was to determine MMI/IR and determine the ability of the employee to return to work. Review of the submitted documentation finds that the designated doctor performed range of motion testing on the elbow for which there is an unresolved issues of extent of injury on the same service(s) for which there is a medical necessity and fee dispute. The extent of injury and medical necessity for date of service September 30, 2011 was not resolved prior to the filing of the request for medical fee dispute resolution; therefore, CPT Code 99456-MI is not eligible for review.
3. The respondent denied CPT Code 99080-73 as global using denial code "97." In accordance with 28 Texas Administrative Code §134.204(J)(1)(D) the total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR.

The MMI/IR examination shall include: the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets. Reimbursment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 24, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.